

Administration of Medication Record

 **Sheet number……….**

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| --- | --- |
| Name of school/setting | **ESCRICK C OF E PRIMARY SCHOOL** |
| Name of child/young person |  | DoB | Class or group |
| Name of GP and contact number |  |
| Emergency name and contact number |  |

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| --- | --- |
| Name of medication | Any special instructions |
| Formula (e.g. tablets) |
| Dosage and administering times |

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| --- | --- | --- | --- | --- | --- |
| Date and time of administration | Dose given | Any reactions and any action taken by staff | Name of person(s) administering /supervising *(please print)* | Signature of person(s) administering / supervising | Additional information e.g.* Repeat prescription supplied
* Medication returned to parent
* Medication returned to pharmacy (Pharmacist signature required)
* Parents signature ( Early Years Children only )
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| Date and time of administration | Dose given | Any reactions and any action taken by staff | Name of person(s) administering /supervising *(please print)* | Signature of person(s) administering / supervising | Additional information e.g.* Repeat prescription supplied
* Medication returned to parent
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